ACHIEVING INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH CARE

Michigan Association of Community Mental Health Boards
Spring Conference
May 18, 2010

Guiding Principles

- Michigan's Public Mental Health System shall ensure that individuals served through community mental health service programs are able to access and obtain services sufficient to address behavioral or developmental needs appropriate to their condition, and that their physical health needs will be ascertained as will any involved primary/specialty health care providers, and ensure that individuals with significant physical health care needs receive those services in a manner that is coordinated and integrated with their behavioral and developmental services so as to achieve a holistic health care experience.
- Where individuals are identified with co-morbid chronic conditions, there shall be proactive policies and practices that assure primary/specialty medical health care access and purposeful integration of services to ameliorate deterioration and further loss of functioning.
- For all individuals served through the public mental health system, opportunities will be made available which are intended to improve overall wellness and prevent or allay the onset and effects of co-morbid conditions and to promote recovery and optimal functioning.
- There are many approaches to integrate physical & behavioral healthcare
- Lessons learned in Michigan and nationally will form the foundation for our integrated health care efforts

Expectations for Assuring Integrated Health Care for Medicaid Beneficiaries

- For Medicaid beneficiaries enrolled in Medicaid Health Plans, the State should consider designing systems for QHPs and PHPs to track referrals made across the two systems managed care systems. The State's Mental Health Advisory Committee may play a role in identifying ways the State could obtain this data. - Management Review of the State Of Michigan's Managed Specialty Services and Supports Waiver Program, January 2003)
- "Medicaid beneficiaries receive high quality health care delivered in a manner that provides them with appropriate, efficient, and cost-effective treatment for both physical and mental health needs. Imperative that physical and mental health specialty services providers work together to coordinate their patients' care to obtain the best possible outcomes." - Janet Olszewski, March 19, 2007

PIHP POLICY DIRECTION

- **From the PIHP Contract**
  - Section 6.4.4: "PIHPs must work closely with local public & private community-based organizations & providers to address prevalent human conditions and issued that relate to a shared customer base. Such agencies & organizations include - - - Medicaid Health Plans - - - . Local coordination & collaboration - - -will make a wider range of essential services available - -
  - The PIHP shall have a written coordination agreement with each of the pertinent agencies - - -
  - Section 6.8.3: The PIHP shall assure that services to each recipient are coordinated with primary health care providers, including Medicaid Health Plans - - -. In this regard, the PIHP will implement practices and agreements described in Section 6.4.4

POLICY DIRECTION

- **AFP, Sec 2.9**: "The Prepaid Health Plans are expected to cultivate partnerships among community agencies. . . . Examples of efforts to foster collaboration include . . .the coordination of specialty services with local physical health care organizations."
- **ARR Section 8**: "the supports coordination/care management function needs to be vested with an expectation that coordination with primary health care will be a standard practice, assuring that individuals will have access (including transportation) to screening and treatment of co-morbid conditions which can lead to increased physical disability and untimely death."
  - **Environmental Scan**: "Evaluate the PIHP's current strengths, challenges and opportunities for improvement in assuring that care management and supports coordination adequately address the needs of people with multiple and persistent needs as identified above and listed here:
    - e: Coordination with primary health care"

Integrating Behavioral Health and Primary Care Services:

Opportunities and Challenges for State Mental Health Authorities

NASMHPD Technical Report 11

January 2005

Improving Healthcare Systems

- Address the need to speed up the transformation of healthcare, from a system that is reactive – responding mainly when a person is sick – to one that is proactive and focused on keeping a person as healthy as possible.

Role of FQHCs and the Need for Collaborative Planning

- Coordination of care is a priority at the national, state and local levels. Coordination will:
  - Help avoid duplication of care and competition for the scarce resources of behavioral health staff and funding.
  - Improve consumer access to behavioral health and healthcare services.

Collaborative Planning

- Communication is the key to coordination care for all populations.
- Future policy should acknowledge the importance of BH/PC integration and support the expectation of communication and coordination at the federal, state, local and personal level.
- BHC Providers need to develop a systematic program for coordinating or integrating with primary health care providers that:
  - Is effective in achieving bi-directional communication with primary care providers
  - Has determined what information is most essential to share
  - Adopts appropriate confidentiality and consent protocols

NASMHPD TR 11

Addressing Healthcare Needs

- Physical healthcare is a core component of basic services to persons with serious mental illness.
- Ensuring access to preventive healthcare and ongoing integration and management of **medical care** is a primary responsibility and mission of **mental health authorities**.

Addressing Healthcare Needs

- Behavioral Healthcare is a core component of essential services to persons seeking primary healthcare.
- Ensuring access to preventive, ongoing, and appropriate **behavioral health** services is a primary responsibility and mission of **general healthcare providers**.

Current Activities

- Mental Health Advisory Committee (MHAC)
- Block Grants/Advisory Council on Mental Illness (ACMI)
- Transformation Transfer Initiative (TTI)
- Certified Peer Support Specialists (CPSS) Personal Action Toward Health (PATH) Initiative
- SA&MH-Integrated Health Care Workgroup
  - Charter
  - Glossary of Terms
  - Work plan

Integrated Health Care Resources

- National Association of State Mental Health Program Directors (NASMHPD)
- http://www.nasmhpd.org/
- National Association of State Directors of Developmental Disabilities Services (NASDDDS)
- http://www.nasddds.org/index.shtml
- Chronic Disease Self-Management Program: Stanford University
- http://patienteducation.stanford.edu/programs/cdsmp.html
- Mi PATH
- http://www.mipath.org/
- Hogg Foundation
- http://www.hogg.utexas.edu/
- California Endowment
- http://www.calendow.org/
- Michigan Recovery Center of Excellence
- http://www.mirecovery.org/

Integrated Health Care Resources

Federal Mental Health Block Grant RFP
http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_42125-142628--,00.html

Milbank Memorial Fund
http://www.milbank.org/reports/10430EvolvingCare/10430EvolvingCare.html

NASMHPD Technical Papers

Measurement of Health Status for People with Serious Mental Illnesses--#16
http://www.nasmhpd.org/general_files/publications/med_directors_pubs/NASMHPD%20Medical%20Directors%20Health%20Indicators%20Report%2011-19-08.pdf

Morbidity and Mortality in People with Serious Mental Illness--#13
http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities--#11
http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Final%20Technical%20Report%20on%20Primary%20Care%20-%20Behavioral%20Health%20Integration.final.pdf

MH&SA Integrated Health Care Contacts

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Manistee-Benzie CMH

Chip Johnston, Executive Director

Manistee-Benzie Community Mental Health Integrated Health Project

- MBCMH is a rural Community Mental Health Board in Northwest Lower Michigan and covers Manistee and Benzie Counties.
- Total population is approximately 41,000
- MBCMH received a two year block grant from the Michigan Department of Community Health to develop an integrated health and wellness program.
- We have 5 months left on the original grant and have experienced mixed results.
- Results can best be described as a tale of two communities.
- That progress centers primarily around personal relationships and the accessibility to community resources

Manistee-Benzie Community Mental Health Integrated Health Project – Benzie County

- MBCMH's Chief Operations Officer has personal relationships with physicians located within Crystal Lake Clinic (the local Rural Health Clinic).
- These personal relationships lead to a quick development of co-location in the building and lead to expenditure of much of the grant $ in year one.
- Benzie County also has a Peer run Personal Action Toward Health (PATH) program that supports the primary and behavioral health effort.

Benefits:

- Consumers have quick access to medical tests that are requested/required by our physician.
- Doctor to Doctor and nurse to nurse conversation regarding a variety of issues is discussed at luncheons in the building
- Quick referral to our PATH programs and various community support groups.
- Greater accessibility to community programs for substance abuse including our Integrated Dual Disorder Treatment for Co-Occurring Disorders (COD:IDDT) programs.

Manistee-Benzie Community Mental Health Integrated Health Project – Benzie County

Barriers:

- Due to physical limitations in the Primary Care Clinic we were unable to co-locate in the same “space” as the community physicians, but rather an office in the same building.
- Additional overhead as a result of a separate office but opportunity to restructure other staff locations
- Mitigates anti-stigma efforts.
- Currently lacking a Social Worker on sight to help further facilitate communication regarding entry and exit criteria for MBCMH. Especially on days when our physician is not on site.

Manistee-Benzie Community Mental Health Integrated Health Project – Manistee County

- In Manistee County pre-existing relationships with the medical community were not as strong thus, MBCMH needed to start from a different place.
- The process of developing relationships and building bridges was begun via the Community Mental Health Affiliation of Mid-Michigan dinner and learning presentations.
- Attendance and sponsoring luncheon or dinner meetings with the general discussion around the overall health of Manistee County.
- Meetings included the Local Hospital, two regional federally qualified health centers (Baldwin and Traverse City), Region #10 Health Department, local independent physicians, and others.
- MBCMH is striving to have one of the two FQHCs locate in the City of Manistee where we intend to co-LOCATE within the next 3-5 years.
- Short-term we also hope to pursue having a community physician locate in our offices.

Manistee-Benzie Community Mental Health Integrated Health Project – Manistee County

Benefits:

- New MBCMH administration getting the word out that we are looking for partners.
- Open to new ideas and fresh approaches.
- In a position to go with any willing and appropriate medical community partner, either on our site or co-locating at a community site.
- Starting from Scratch

Barriers:

- Starting from Scratch.
- Going to take time to develop personal relationships with the medical community.
- No FQHC located where the majority of the medical community is or MBCMH's Manistee Consumer base.

Manistee-Benzie Community Mental Health Integrated Health Project – Outcome Measures

- MBCMH is struggling with outcome measures.
- MBCMH explored using the Flinn foundation tool but found its process to be too taxing for our current staffing capacity and our consumers inform us that they have survey fatigue (MDCH, PIHP, SA, MBCMH, etc…) However, we might use parts of the Flinn Tool.
- Currently we are relying on information from surveys and reviews by MDCH, and the Michigan Recovery Center for Excellence (Steve Batson, Project Coordinator), Consumers, and Physician feedback.
- We are in search of a tool that will work for all parties.

Manistee-Benzie Community Mental Health Integrated Health Project – Funding

- Funded by a two year grant from MDCH to fund a project coordinator to get the program off the ground.
- On-going funding will be part of MBCMH's day-to-day operations, coupled with integration and cooperation with PATH, Solutions to Wellness and other In-Kind cooperatives.
- Utilizing CMHAMM (Pre-paid Inpatient Health Plan) coordination efforts/cooperatives with MBCMH.
- Grants when they are available and where they make sense to foster/bolster the integration of behavioral health, substance abuse, and physical health.

Manistee-Benzie Community Mental Health Integrated Health Project – Conclusion

- It's all about establishing relationships with the local medical community.
- Build relationships through systems education, shared ownership of community problems, and mutual respect.
- Work within the communities' tolerance for change, but have a persistent and consistent message.
- Although our information is anecdotal at this time, the benefits in Benzie County appear to be immediate due to proximity and information sharing.
- Has it been worth it? Absolutely! MBCMH feels that in order to be effective we need to make every effort to engage those systems of care that touch each of our consumers, whenever possible.

Oakland County Community Mental Health Authority

Jeff Brown, Executive Director

Basic Oakland County Facts

- Population 1.2 million
- 2nd Largest CMHSP (46)
- 2nd Largest PIHP (18)
- 28 School Districts
- 46 Law Enforcement Entities
- Cities, Townships
- Hospitals….Hospital Systems (7)
- Medicaid Health Plans /County Health Plans /ABW
- Primary Care-FQHC

We Know

- People with mental illness have a much higher incidence of life-shortening physical illnesses than the general population.
- People with mental illness have a high incidence of metabolic disorders including obesity, diabetes mellitus, hypertension, cardiovascular disease and stroke.
- People with mental illness die 25 years sooner than people without mental illness.

Our Mission

- Advancement of Social Equity
- Improved Quality of Life

- Requires a Community System of Care that prioritizes Personal Health outcomes, purposefully plans to achieve the outcomes, measures outcomes and collaboratively continuously seeks improvement!

Access, Engagement, Outcome

- Access and obtain services and supports sufficient to address behavioral, developmental and physical health needs
- Coordinated and Integrated services
- Achieve a holistic health care experience and improved health

All Citizens in our Community

- Those unemployed
- Those without Medicaid
- Those with Pre-Existing conditions
- Those with High Stigma Illnesses
- Those with Severe and Chronic Conditions

Oakland County CMHA Integration Initiatives

- Communication and Collaboration (Internal Capacity Building)
  - Electronic Health Record/Central System
  - Data Sharing Project
  - High Utilizers Project
- Access, Engagement and Choice (Community Capacity Building)
  - Collaborative agreements
  - Co-Location Behavioral Health in FQHC- Flinn Foundation - Complete
  - Co-Location FQHC look -a- like in Core Provider Agency- July 1, 2010
  - Co-Location: FQHC in Core Provider Agency ??

Data Sharing Project

- Pilot project initiated by the Department of Community Health to encourage integration of mental healthcare and physical healthcare.

- Great Lakes Medicaid Health Plan has partnered with OCCMHA to share data on common consumers.

Data Sharing Project
Great Lakes Health Plan & OCCMHA

Significant Findings

- Shared consumers: 2,281
- Consumers seen at OCCMHA but not seen at Great Lakes Health Plan 700
- Identification of “High Utilizers”

High Utilizer Project

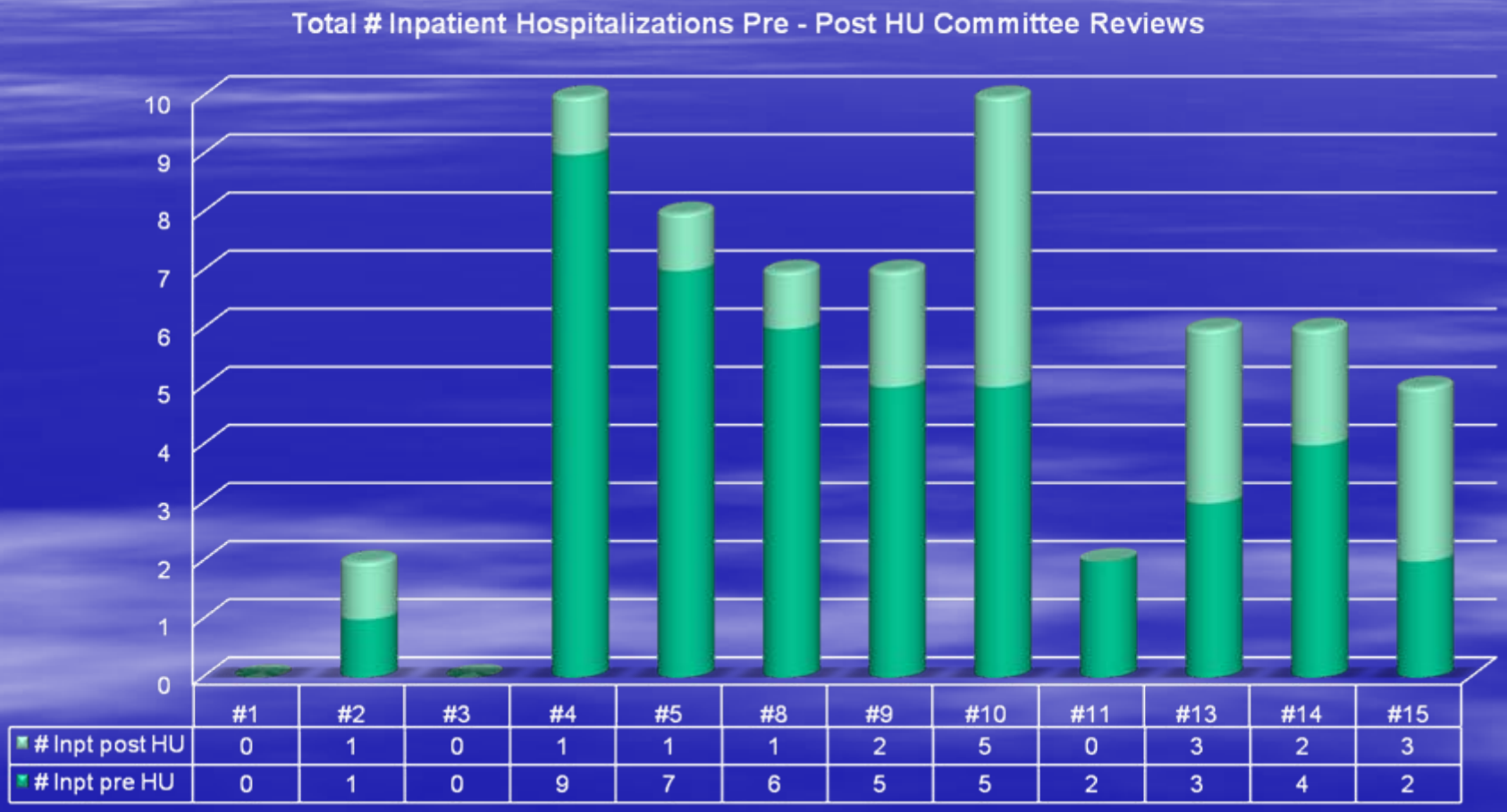
- **Problem/Diagnosis Statement:** There is an identified population of consumers, who in spite of utilizing a high number of services are not achieving the positive outcomes they desire. High risk consumers are identified by the following use of services:
- Consumers engaging in high risk behaviors/ self-destructive behaviors/anti-social behaviors
- 6 or more visits to a crisis screening unit in the past 6 months.
- 12 or more visits to emergency rooms in the past 6 months.
- 3 or more admissions to medical/psychiatric or crisis residential units in the past 3 months.
- Relapse following treatment in a residential substance abuse unit within 6 months of discharge and/or failure to respond to outpatient substance abuse treatment for the past 6 months,
- 3 or more criminal charges within 3 months
- 2 or more failed specialized residential placements in 1 year.

High Utilizer Project

- **Mission Statement:** To improve the quality of our consumers' lives through collaboration and consultation. Improvement in quality of life will be measured by:

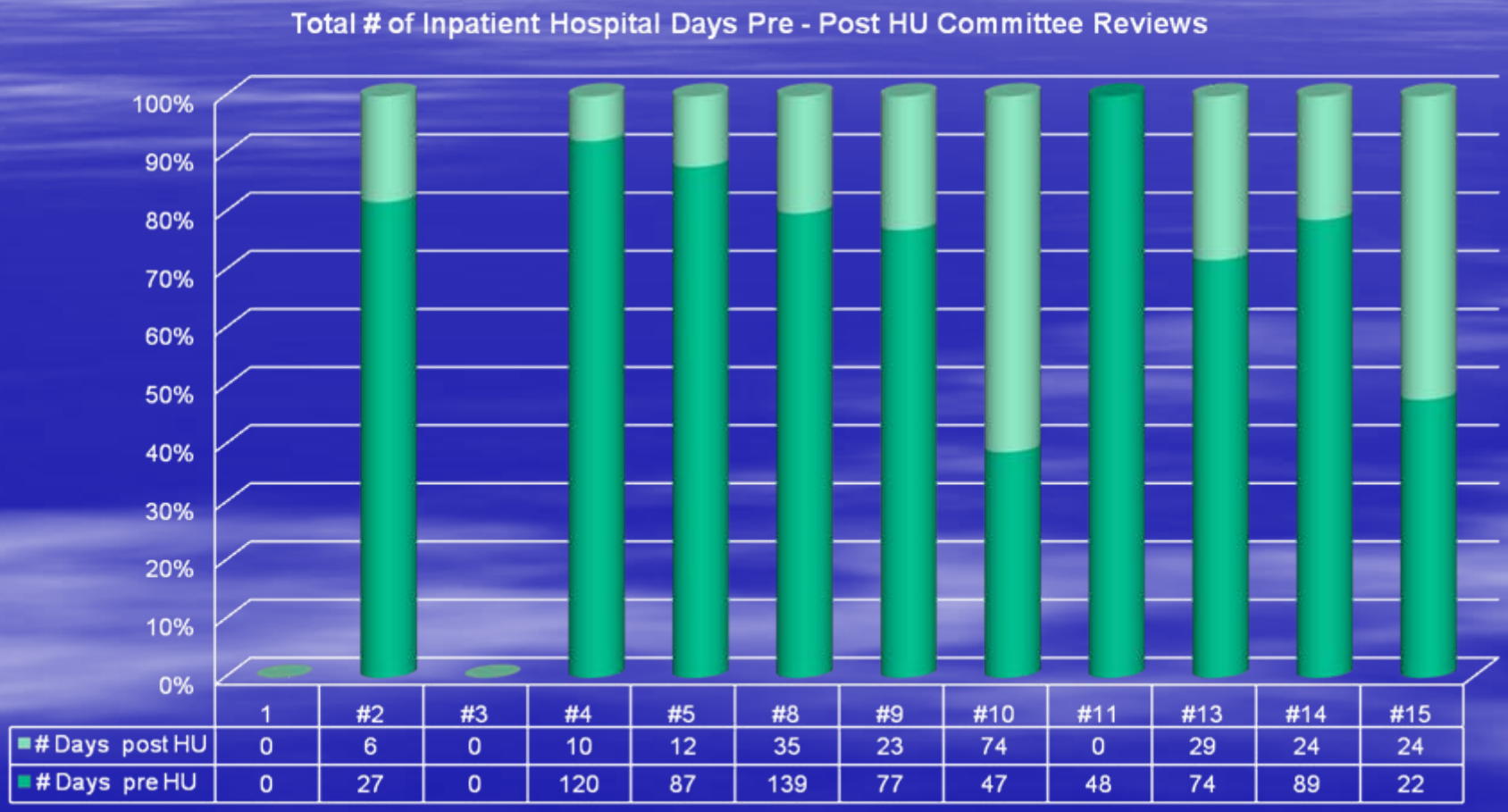
- A positive movement in the individual's Stage of Change related to the high risk behaviors/self-destructive behaviors/anti-social behaviors at time of referral.
- A 10% decrease in visits to crisis screening units in the next 6 months.
- A 10% decrease in frequency of emergency room visits in the next 6 months..
- A 10% decrease in frequency of admissions to medical or psychiatric units in the next 6 months.
- A 5% decrease in readmissions to residential Substance Abuse treatment units in the next 6 months and/or positive movement within the Stages of Change.
- A 10% decrease in the number of criminal charges in the next 3 months.

Inpatient Hospitalizations



	#1	#2	#3	#4	#5	#8	#9	#10	#11	#13	#14	#15
# Inpt post HU	0	1	0	1	1	1	2	5	0	3	2	3
# Inpt pre HU	0	1	0	9	7	6	5	5	2	3	4	2

Inpatient Hospital Days



	1	#2	#3	#4	#5	#8	#9	#10	#11	#13	#14	#15
# Days post HU	0	6	0	10	12	35	23	74	0	29	24	24
# Days pre HU	0	27	0	120	87	139	77	47	48	74	89	22

Health Care Reform 2014

- Capacity Building: Pursuit of FQHC/FQBHC
- Expansion of those eligible for Medicaid
- Focus on Wellness
- Information Technology
- Comparative Effectiveness Research
- Pursuit of what works

Integration Summary

- Improved Lives in the Community
- Building Capacity
- Shared Commitment
- No one Community Solution
- Continuous Improvement
- Empower and develop our most powerful and abundant resource for those we serve

PATH

PERSONAL ACTION TOWARDS HEALTH

Braunwynn Franklin, CPSS
PATH Master Trainer

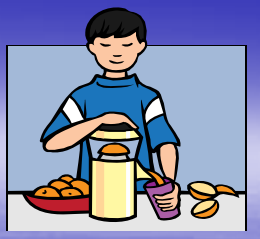
Take the PATH to Better Health

About the Program

- It is evidence based.
- Was developed and tested by Stanford University to help people build the skills they need for the day-to-day management of a chronic disease.
- Random trials with over 1000 participants with chronic conditions reported improvement.

Continue

About the Program



- In Michigan, Chronic Disease Self Management Program (CDSMP) partnered with Michigan Department Community Health (MDCH) and Office of Service to the Aging (OSA) to build a system for coordinating, implementing and expanding PATH.
- That is known as MIPATH, and has grown to more than 18 agencies since 2005.
- By 2007 marketing materials, evaluation tools, and the centralized data base were completed and implemented.

About the Program

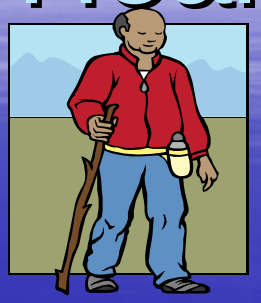
- In October 2008, with the Integrated Health Initiative, Mental Health was introduced
- By January 2009, Certified Peer Support Specialists started to be trained as PATH leaders
- There were 11 $20,000 grants offered by the MDCH from a grant obtain from National Association of State Mental Health Program Directors (NASMHPD)
- The grants are assisting with the Mental Health and Physical Health Services Integration Initiative Using Peers Support

Continue

About the Program

- This program is conducted World Wide but Michigan is the only State in the US were it is conducted by Peer Support and this is recognized in **SAMHSA's** 10 x 10.
- By August 2009, 20 Peer Support PATH Leaders were trained as Master Trainers for the State of Michigan.
- Currently, 20 plus trained leaders are being organized to provide PATH Workshops throughout Wayne County.

Take the PATH to Better Health



What is Path?

- PATH is a workshop that helps participants improve their health and feel better.
- PATH is a Self Management Program.
- PATH is designed to provide skills and tools needed by people living with a chronic health condition(s) or their providers.

What is PATH

- Two trained Peer Support leaders will conduct the workshops. One or both may have a lifelong health condition or be a care provider.
- The sessions are fun and interactive. Participants share their successes and build a common source for support.
- Workshops are 2 ½ hours once a week for a 6 week period.

Take the PATH to Better Health

Who Can Benefit?

- Anyone with a long term health condition.
- Family, caregivers or people who want to learn more about supporting those with a long term health condition.
- Any adult who wants to feel better.

Who Will Not Benefit?

- People expecting technical knowledge in a lecture format or disease specific information.
- Individuals with well-managed chronic conditions who do not perceive their conditions as adversely affecting their life.
- People looking for a replacement for existing programs or treatments.

Does it Work?

- Results provided for improvement in:
  - Health status
  - Health care utilization
  - Self-management behavior
- 98% of the participants will continue to use the techniques they learned.
- In Michigan, more than 1/3 have diabetes, almost ½ have hypertension, nearly ½ have arthritis and over 10% depression.

What Makes Peer Support Successful

- Doing the necessary work to maintain a positive recovery journey.
- Communication
- Empathy

Take the PATH to Better Health

How To Find a PATH Workshop

Visit www.MIPATH.org

- Click on find a Class/workshop

- Contact Karen McCloskey

mccloskey@michigan.gov

517-335-1236

- Contact Braunwynn Franklin

bfranklin@newcentercmhs.org

313-961-3699